TEXAS HIGHER EDUCATION COORDINATING BOARD
FAMILY PRACTICE RESIDENCY PROGRAM
RURAL ROTATION
Supervisor Application

Return completed application to:

Stacey Silverman, Program Director
Texas Higher Education Coordinating Board
Attn: Family Practice Rural Rotation
P.O. Box 12788
Austin, Texas 78711-2788
(512) 427-6200

I. Supervisor Information

A. Physician Name (Please Print)_____

B. _____ ( )_____
(Office Address) Street City State Zip Code Phone

C. _____ ( )_____
(Home Address) Street City State Zip Code Phone

D. County of Practice Location_____ E. Date of Birth_____

F. Medical School and location _____

Year of Graduation_____

G. Please check the statement(s) which apply to you and provide the corresponding data.
I am: ☐ Licensed to practice medicine in Texas.
Texas Medical License Number_____

☐ Board-certified in Family Practice.
Year of Next Recertification_____

☐ Residency-trained in Family Practice.
If residency-trained, please provide name and location of residency program and date of graduation.

_____
Family Practice Residency Program Location Date of Completion

☐ Active member of the Texas Academy of Family Physicians. (Not Required)

H. I have previously served as a family practice preceptor in the Family Practice Statewide Preceptorship Program. ☐ Yes ☐ No

I. How long have you practiced in your community? ☐ Years

J. Medical Malpractice Insurer_____

K. Do you plan to seek additional family practice associates in the near future?
☐ Yes ☐ No

II. Practice Characteristics

A. ☐ Solo Practice ☐ Partnership ☐ Group Practice

1. If group practice, please indicate number of physicians in group. _____

2. Specialties represented in group: _____

_____

B. Approximately what percent of your practice is:

1.	2.
_____% Surgical _____% Medical _____% Obstetrical _____% Pediatric _____% Industrial	_____% In-patient _____% Out-patient _____% Other (Please describe) _____ _____

3.	4.	5.	6. Patient Age Profile
_____% Private Self- Pay _____% Private 3rd Party Reimbursement _____% Medicaid _____% Medicare _____% Uninsured Indigent	_____% White _____% Black _____% Hispanic _____% Other	_____% Male _____% Female	_____% 0-10 yrs. _____% 11-25 yrs. _____% 26-55 yrs. _____% Over 55

C. Which of the following are employed in your office?

☐ RN ☐ LVN ☐ Other _____
☐ Physician Assistant ☐ Nurses Aide _____
☐ Nurse Practitioner ☐ Lab Technician _____
☐ Social Worker ☐ X-ray Technician

D. Estimate the typical number of patients you have hospitalized at any one time: _____

E. Estimate the typical number of patients you see per day: _____

III. Community Characteristics

A. What is the approximate population of your community? _____

B. What is the approximate population of your practice "drawing area"? _____

C. 1. Is there a hospital in your community at which you have active admitting privileges?
☐ Yes ☐ No

2. If yes,

a. Hospital Name _____

b. Administrator _____

c. Address _____

_____

d. Phone _____ e. Number of beds _____

3. If there is no hospital in your community, how far is it to the nearest hospital at which you have active admitting privileges? _____

a. Hospital Name _____

b. Administrator _____

c. Address _____

_____

d. Phone _____ e. Number of beds _____

4. Do you have active admitting privileges at any other hospital in the area?
☐ Yes ☐ No

a. Would residents be using this hospital? ☐ Yes ☐ No

b. If yes, hospital name _____

c. Administrator _____

d. Address _____

_____

e. Phone _____ f. Number of beds _____

5. Please briefly describe the community's recreational and cultural attractions:

IV. Physician

A. Describe your involvement in community medicine (i.e., county health office, migrant workers' clinic, federally funded community health center, hospital utilization committees, etc.)

B. Are there any prerequisite courses or experiences that you feel are necessary for a resident doing a rotation with you? ☐ Yes ☐ No

C. If yes, please explain.

D. Can you provide housing for the resident? ☐ Yes ☐ No

E. If you cannot provide housing, is housing for the resident available in the community? ☐ Yes ☐ No

F. Can you provide meals for the resident? ☐ Yes ☐ No

G. If you cannot provide meals, are meals for the resident available in the community? ☐ Yes ☐ No

H. The Rural Rotation will last for one month. Are there any times of the year when you definitely do **not** want to have a resident assigned to you? ☐ Yes ☐ No

If yes, specify those periods below.

FROM Month/Day	TO Month/Day

I. Please list any other attributes you feel would help residents in selecting your practice as a Rural Rotation site.